
Stigma, sex work, and substance use: a comparative analysis

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Abstract Stigma is a widely used concept in social science research and an extensive literature claims that stigmatisation contributes to numerous negative health outcomes. However, few studies compare groups that vary in the extent to which they are stigmatised and even fewer studies examine stigma's independent and mediating effects. This article addresses these gaps in a comparative study of perceived stigma and drug use among three low-income feminised service occupations: sex work, food and alcoholic beverage serving, and barbering and hairstyling. An analysis of longitudinal data shows positive associations between sex work, perceived stigma, and socially less acceptable drug use (for example, heroin and cocaine), and that stigma mediates part of the link between sex work and the use of these drugs. Our overall findings suggest that perceived stigma is pronounced among those who work in the sex industry and negatively affects health independently of sex work involvement.

Keywords: perceived stigma, sex work, feminised service occupations, substance use, discrimination, longitudinal analysis

Defining stigma

Erving Goffman (1963: 3) wrote that stigma spoils identities, disqualifying individuals 'from full social acceptance' and reducing them 'from a whole and usual person to a tainted, discounted one'. Stigma involves labelling, stereotyping, separating, status loss, and discrimination (Link and Phelan 2001) and operates in a range of social contexts, including at work, in personal life and when seeking help from institutions. Societies stigmatise a wide range of attributes and statuses, some of which, like gender, race and physical disabilities, are easily observable, whereas others, such as those associated with mental illness, imprisonment and occupation, may be apparent only in particular settings or circumstances.

The consequences of stigmatisation are far-reaching. It adversely influences psycho-social variables such as hope, self-esteem, efficacy, self-concept and identity formation (Livingston and Boyd 2010) and is negatively associated with quality of life measures such as social isolation, employment and income (Link and Phelan 2001). Stigmatisation is linked to an array of physical health and mental health problems (Green *et al.* 2005) and a reluctance to use needed health services (Link and Phelan 2014, Pescosolido *et al.* 2008, Stuber *et al.* 2008).

Stigmatised individuals experience social exclusion that ranges from difficulty in engaging in normal social interaction because of secrecy or shame to complete discrediting or exclusion by others (Corrigan *et al.* 2009, Link and Phelan 2006). We add to this literature with an examination of the health consequences of occupation-based stigma in three occupations: sex work, serving and styling.

Analysing sex as work is controversial. Our approach reflects Weitzer's (2010) polymorphous perspective, an orientation that combines insights from what he calls the empowerment and oppression paradigms. Adherents to the former argue that people choose sex work as they choose any other occupation. This choice reflects their assessment of their early life circumstances, current economic and social needs, marketable skills, employment options, and any constraints imposed by individual characteristics (for example, health). According to this view, sex work is most importantly an economic activity. It is problematic largely because those involved are persecuted by legal systems and some publics (Benoit and Shaver 2006, Parent *et al.* 2013). Weitzer dismisses extreme versions of the oppression paradigm (Raymond 2003, Farley 2004, Wong *et al.* 2011), while noting the importance of recognising the difficult and exploitative backgrounds and experiences of some sex workers (see also Benoit *et al.* 2013, McCarthy *et al.* 2014). Sullivan adds context to this point, reminding us that (2010: 87): 'most paid work, including sex work, involves varying degrees of coercion, exploitation, resistance, and agency'.

Occupational stigmas and health consequences

Sex work is highly stigmatised. People in the industry are commonly constructed as 'others' in a criminal world where social rights expected in the normal world do not apply (Vanwesenbeeck 2001). Derogatory labels (for example, hooker and whore) are routinely used to describe them and data from workers, customers and the general public demonstrate the frequency, intensity and saliency of these labels (Scambler 2007). Stigma 'colors all sex work' (Weitzer 2010: 30) and cannot be reduced to illegality or a particular type of activity (McCarthy *et al.* 2012). It occurs among workers in legal forms of sex work such as erotic dance (Trautner and Collett 2010) and pornography (Royalle 1993), as well as among those who work in licensed brothels (Symanski 1974), decriminalised or regulated prostitution environments (Abel *et al.* 2010) or as high-end escorts (Bernstein 2007).

We would expect that people employed in the two other occupations studied – the food and alcoholic beverage and hairstyling industries – would be less frequently belittled and ridiculed for what they do for a living. Yet ethnographies describe how many of these workers are treated disrespectfully by customers who are often of higher status backgrounds and who expect subservience (Black 2004, Hill and Bradley 2010, Kang 2010, Owings 2002, Sharma and Black 2001).

The presence of varying degrees of occupational stigma in these three jobs is hardly surprising: all are low-skilled and low-status jobs. They also have a smaller age distribution than many other occupations (that is, fewer workers over 55 years of age), are disproportionately female and do not require a high school diploma. Part-time work is common and many of these workers have multiple jobs, both within and outside the industry in which they work most intensely (Leidner 1993). These jobs also require high levels of emotional labour and gender scripting (Hochschild 1983) in which workers manage their own and their clients' emotions as a way to increase the likelihood of return customers and tips (Hill and Bradley 2010, Sanders 2005). This emotional labour is linked to high levels of stress, distress and burnout in people in care work service jobs where worker control is low (Dwyer 2013, Mann 2004, Vanwesenbeeck 2005).

Service workers use several strategies to cope with occupational stigma and the accompanying stress and burnout they may feel, ranging from humour and the depersonalisation of clients to collegial support and the use of legal and illegal drugs (Mann 2004). Although drug use is commonly argued to be linked to entry into and working in the sex industry (Vaddiparti *et al.* 2006), data from workers in the serving and styling industries show that they also have high rates of legal and illegal drug use relative to people in many other occupations (Macdonald *et al.* 1999). Complicating this picture is the varying degree of stigma associated with different substances. At one end of the continuum are socially more acceptable (SMA) drugs such as alcohol and marijuana whose use is legal or generally tolerated. At the other end are socially less acceptable (SLA) drugs such as cocaine or heroin, the use of which is often considered immoral and as reflecting a general depravity or dangerousness (Lloyd 2010).

Based on the different bodies of literature introduced above, this article has three main hypotheses:

- 1 People working in the sex industry will report perceived stigma more frequently and more intensely than stylists and servers.
- 2 While a substantial minority of workers in all three occupations will use drugs, use of SLA substances will be more common among people working in the sex industry.
- 3 Perceived stigma will help mediate the association between sex work and the use of SLA drugs.

Methods

The data for this analysis were collected from 2003 to 2007 as part of a panel study on stigma, work and health. All aspects of the study were approved by the research ethics boards at the authors' institutions. The data were gathered from two locations: (i) the census metropolitan area of Victoria, British Columbia and (ii) three counties that are part of the greater metropolitan region of Sacramento, California. These two cities were chosen for several reasons: (i) they are located in countries that share many features but have different labour codes, sex industry laws and healthcare systems; (ii) the researchers had previous contacts with agencies that served people working in the sex industry in Victoria and were able to establish similar relationships in Sacramento; (iii) the two areas share several political and demographic features, including a large proportion of government workers and higher than average national median incomes, mobility rates and average education; and (iv) using two sites increased our opportunities to recruit a large sample of workers in each occupation.

Several factors complicated the study. Firstly, sex work includes an array of activities, some of which are legal (for example, escorting) and others that are illegal (for example, on-street solicitation). Given the study's comparative focus on front-line service work, the sample was limited to workers who had direct physical contact with customers and received tips directly from them. The sex work sample was further limited to workers who sold sexual services to clients in face-to-face encounters (for example, erotic massage, escorting and street soliciting, but not pornography or phone sex). Secondly, there are no population lists for people employed in the sex or serving industries in the study locations. There was a list of licensed hairstylists in California, but not in British Columbia, where styling was deregulated, and the California list included many people who had a licence but did not work in the industry. Thirdly, although the researchers were able to construct lists for some types of styling, serving and sex-work businesses (for example, from Chamber of Commerce and phone directories or through online searches), the available information was often dated and contained many

foreign entries. Fourthly, the stigma associated with sex work and the illegality of many of the activities it involves required additional steps to locate and recruit people (Shaver 2005).

Sample and participant selection

Both random and purposive sampling strategies were used to locate potential respondents. A random sample drawn from a list of the addresses of licensed California barbers and stylists was contacted by mail or by phone (using reverse directory listings). In both research sites, samples were generated for hair cutting and styling businesses and restaurants that served both food and alcohol from municipal business lists. In Sacramento this list was also used to generate a random sample of styling and barbering businesses. In both research sites restaurants, salons and barbershops were stratified based on the number of seats, data that were obtained by calling the business or by canvassing locations in person. Sex industry workplaces advertised in local newspapers or on the Internet were contacted by e-mail, phone or surface mail. One of the counties in Sacramento issues licences for 'adult businesses' and establishments with a physical or Internet address were contacted. Information packages were sent to managers of these businesses explaining the nature of the study and, where possible, onsite visits were made to talk about the project and to ask managers to post fliers where employees would see them. Potential participants were also contacted through respondent-driven sampling, a technique in which respondents serve as 'seeds' and recruit others for the study (Heckathorn 2002). Seeds added 58 respondents (15 from styling, 18 from serving and 25 from sex work).

These approaches were supplemented with the following: advertising the study in local newspapers in which sex workers publicise their services (for example, escort); contacting social service agencies that provide outreach to people who work in the sex industry and asking the agency representatives to display notices about the project and to refer clients; placing notices at wholesalers who sell supplies and equipment to stylists and posting notices on web services that connect workers and customers. The recruitment material indicated that the study focused on work and health and was supported by the researchers' university and named funding agency.

The goal was to recruit diverse samples of approximately one hundred workers in each occupation in each city, for a sample size of 600. A final first-wave sample of 595 useable interviews was obtained. More people were recruited from sex work ($n = 212$) or serving ($n = 204$), and fewer from styling ($n = 179$), in part because of media in Victoria that criticised the inclusion of hairstylists and sex workers in the same study.¹ The study plan included follow-up interviews 4 months after the first wave; however, the time period varied because of difficulties in scheduling follow-up interviews.

Several techniques were employed to minimise attrition: phoning respondents periodically between waves to maintain contact; establishing study-specific phone numbers and e-mail addresses so respondents could contact the study and retaining respondents who moved from the region (for example, at the second wave, five respondents completed a phone interview and 14 a mail survey). At the second wave, 83 per cent of the respondents ($n = 493$) were interviewed, but more respondents from the sex industry were lost relative to the other occupational groups. There was a 70 per cent retention rate for the former (148/212), compared with 90 per cent each for those with serving jobs (184/204) and for those employed as stylists (161/179). Tests of mean differences for 36 variables used in an earlier analysis (McCarthy *et al.* 2014) indicate there were only a few differences between people in each occupational group who completed a second interview with those who did not (for example, 1/36 for people working as stylists, 4/36 for those working as servers and 7/36 for those employed in sex

work). Moreover, no one variable is consistently related to attrition for all three occupations. Although it is impossible to assess the representativeness of the three samples of workers – there are no accurate population lists – comparisons with prior research and statistics from government websites (for example, see Government of Canada 2013a, 2013b) confirm that our samples of stylists and servers reflect the general diversity of these occupations. While sex workers do not appear in any government occupational lists, other studies suggest that our sample reflects the diversity of this group (Abel *et al.* 2009).

The interviews were conducted by a research team that included the authors of this study, graduate students and former workers from each of the three occupations. The respondents could ask for an interview by someone who had worked in that occupation or could ask for a male or female interviewer. At each wave, we asked respondents a set of closed and open-ended questions and gave them a choice of answering privately a set of potentially sensitive questions (for example, on substance use). Many respondents asked that the interviewer read these questions and record their answers, a preference that may have reflected their desire to continue with the approach established at the start of the interview or their discomfort with reading.

Respondents received an honorarium of \$25 and signed or initialled an informed consent form. All Sacramento respondents were provided with a National Institutes of Health Certificate of Confidentiality that explained that their identities were protected even if the study data were subpoenaed. Comparable protection was not available in Canada. There the study was designed to satisfy the Wigmore criteria that are used by the courts to determine whether they will support the promises of confidentiality (Palys and Lowman 2010). The criteria require that confidentiality was promised and was essential; that community interests were recognised and that the violation of confidentiality would result in greater harm to the participants in the research than the benefits resulting from breaking promises of confidentiality. The consent form stated that if the interview raised concerns and the respondent would like to meet a qualified counsellor, the interviewer would help to find this service free of charge. Interviewers also gave respondents a list of local health services. All interviews were tape-recorded unless the respondents declined or because of a technical problem (total interviews not taped: 19 from the sex industry, 19 from serving and seven from styling). The interview excerpts below emerged from our thematic analysis of the answers to the open-ended questions pertaining to stigma that were included in all interviews.

Measures

The study's data collection instruments combined standardised measures, items used in studies of vulnerable occupational groups and measures unique to the research programme. At each wave of the study respondents provided self-report data on drug use. These data included information on alcohol use, which was at one end of the social acceptability continuum; marijuana, which was more towards the middle; and a group of drugs that fell in the less acceptable part of the continuum and that were used to make an index: heroin, cocaine (or crack), crystal methamphetamine, club drugs (for example, ecstasy) and non-prescribed prescription drugs (for example, OxyCONTIN). Respondents used the following categories to describe their use of each drug over the 4 months prior to their interview: never (= 0), less than once a month (= 1), twice a month (= 2), once a week (= 4), twice a week (= 8), or daily or more (= 30). Self-reports of drug and alcohol use have reasonably high reliability and validity (Fendrich *et al.* 2004), even among habitual users of SLA drugs (Darke 1998). The data were analysed with negative binomial regression because the three measures of drug use were

strongly skewed with a high proportion of non-users, and their standard deviations exceeded their means.

The two key independent variables were occupation and perceived stigma. Dummy variable measures of the first-wave occupation were used and the effects of working in the sex industry or as a server were compared with employment as a stylist. Researchers use a variety of items to measure stigma, in part because of the variation in their disciplinary backgrounds and research interests (Link *et al.* 2004). This study's questions were a mix of original and established measures. However, the approach that was employed differed from that used in most studies in that it included questions that did not refer directly to the condition or trait hypothesised as the source of stigmatisation (see Link *et al.* 2002, Wahl 1999). Measuring perceived stigma independently of occupation made it possible to estimate its connections to occupation, as well as to drug use, rather than asking the respondents to do this.

Perceived stigma was measured with six questions ($\alpha = .620$). Four of these asked respondents to use one of five categories (never, rarely, sometimes, often and very often) to describe the frequency of the following: been refused housing even when they could afford it; been denied a bank loan; and had doctors or nurses (separate questions) say things about the respondents' occupation. Three questions resembled items used in other measures of perceived stigma in interactions with members of the general public (Wahl 1999), but the last two were original and reflected the importance of measuring stigma in interactions with healthcare providers. The respondents were asked to use five categories of agreement (strongly agree to strongly disagree) to describe their feelings about whether or not nurses and physicians respected them. Perceived stigma was standardised on the number of questions answered by the respondent, as were the other scales used in this study.

The analysis also included a small set of variables that may contribute to both perceived stigma and substance use. The most important controls replicated the dependent variables but measured SLA and SMA drug use at the first-wave interview. Including a control for first-wave drug use effectively purged the results of stable person-specific attributes that may contribute to drug use and made it possible to examine the connections between occupation, stigma and change in drug use over time. First-wave measures of age (in years), gender, member of a sexual or racial minority, country of residence, marital status, current poverty and physical and mental health were also included. An original item was used to measure marital status. This measure explicitly recognised the financial aspects of marital status and divided respondents into three groups: single, involved with an unemployed romantic partner and involved with an employed romantic partner (reference group). Current poverty was calibrated with a three-item scale ($\alpha = .805$) that assessed the frequency of having problems paying for basic necessities and food. These questions were developed and used in research on vulnerable populations (Benoit *et al.* 2008). Overall or global health was measured with two widely used items (DeSalvo *et al.* 2006) that asked about the respondents' physical and mental health in the 4 months prior to the interview (five category scale from poor to excellent).

One of the difficulties in estimating the consequences of occupationally based perceived stigma on substance use is the possibility that any effect may not result from involvement in a particular line of work but may be an artefact that occurs because of the 'type' of people who work in a particular industry. For example, people who have a high risk of or propensity for using drugs may also have a high risk of or propensity for involvement in the sex industry, relative to working in other service jobs (Maher 1996, Vaddiparti *et al.* 2006). This analysis addressed the potential endogeneity of selection into sex work by using Heckman's (1976) two-stage estimation procedure. In the first stage a probit model of the probability of working in the sex industry was estimated. This model included a set of instruments that are discussed below. The results of the probit model were used to calculate the hazard (the inverse Mills

ratio [IMR]) of sex work for each respondent (that is, the ratio of the probability density function for the expected value of the probit to the cumulative distribution function for the expected value of the probit). The hazard was reverse-coded (so that it predicts the hazard of selection into sex work) and was then entered into the negative binomial regression models of drug use (that is, the second stage or substantive equation).²

Strong selection models require instrumental variables. In this case, the preferred variables predict the probability of selection into sex work, are marginally associated with substance use but, conditional on selection, do not directly influence drug use. An analysis of 30 variables revealed a set of seven that were strong predictors of working in the sex industry at the first wave of the study. These are discussed below.

Results

The descriptive statistics for the analytical sample ($n = 441$) are presented in Table 1. As expected, people working in the sex industry differed from those employed in styling and in serving on a number of attributes. People working in the sex industry had noticeably poorer health, were disproportionately drawn from racial and sexual minority groups and struggled more with poverty, and a greater proportion was single. They also reported substantially greater use of SLA drugs at both waves of the study, and more use of marijuana at the first wave. However, on average their use of marijuana at the second wave and of alcohol at either wave was noticeably greater only when compared to stylists and not servers.

The mean for perceived stigma was significantly greater for people working in the sex industry than other service workers. Nonetheless, a sizable percentage of workers in each occupation said that they felt that they had been treated unfairly. For example, 17 per cent of people working in the sex industry reported that doctors had often or very often made negative remarks about their work, compared with 8 per cent of servers and 13 per cent of stylists. Likewise, 15 per cent of people in sex work disagreed or strongly disagreed that doctors treat them with respect, compared with 5 per cent of servers and 6 per cent of stylists.

Comments by workers in each of these occupations highlighted other people's negative views about their jobs. As one server noted:

It seems like a pretty menial task to people who've never done it. I mean, we've all seen pictures of monkeys and wait staff, so it can seem quite easy and people badmouth it and stuff, friends of mine even.

A stylist had this to say about how he was sometimes treated by others: 'Most people ... probably think I'm the lower level of people'. However, more people working in the sex industry spoke about the negative social perceptions associated with their job as well as its consequences. Echoing the findings of other research (Abel *et al.* 2010, Whitaker *et al.* 2011), a number of respondents said that healthcare providers make derogatory remarks about sex work and the people who do it. As one person noted:

I'm still a good person, but they don't see that. They just see me as the kind of person that's out there; they think I'm drug-oriented or I'm out to, just, you know, sleep with one of the doctors.

These and other experiences often left sex workers feeling demoralised: 'Yeah well, it makes me feel ashamed of myself or whatever just because this society's views on it; it makes me

Table 1 *Descriptive statistics for three occupational groups*

	Range	Sex work		Serving		Styling	
		Mean	SD	Mean	SD	Mean	SD
Alcohol use (W2) ^{a,c}	0–30	6.358	10.183	11.723	11.959	6.483	9.902
Marijuana use (W2) ^{b,c}	0–30	7.138	11.836	6.310	10.581	3.730	8.991
Socially less acceptable drug use (W2) ^{a,b,c}	0–30	3.309	4.697	0.659	1.981	0.187	0.924
Alcohol use (W1) ^c	0–30	8.512	12.078	10.640	11.025	7.457	10.608
Marijuana use (W1) ^{b,c}	0–30	8.696	12.732	6.227	10.382	3.854	8.819
Socially less acceptable drug use (W1) ^{a,b,c}	0–30	4.339	5.823	0.467	1.568	0.066	0.188
Age (W1) ^{a,b,c}	19–75	36.768	9.074	32.555	10.312	43.406	13.295
Current poverty (W1) ^{a,b,c}	0–5	1.785	0.639	1.438	0.472	1.258	0.394
Overall mental health (W1) ^{a,b}	1–5	3.080	1.147	2.422	1.006	2.245	0.913
Overall physical health (W1) ^{a,b}	1–5	3.096	1.139	2.514	0.974	2.441	1.004
Perceived stigma (W2) ^{a,b}	1–5	2.329	0.730	1.837	0.505	1.819	0.450

	Range	Sex work		Serving		Styling	
		%	SD	%	SD	%	SD
Single (W1) ^{a,b}	0-1	53.60	0.501	32.95	0.471	29.37	0.457
Romantic partner unemployed (W1) ^{a,c}	0-1	19.20	0.395	10.40	0.306	18.88	0.393
Female (W1) ^{a,c}	0-1	84.80	0.360	70.52	0.457	84.62	0.362
Racial minority (W1) ^a	0-1	33.60	0.474	19.08	0.394	23.08	0.423
Sexual minority (W1) ^{a,b}	0-1	40.00	0.492	8.09	0.274	11.19	0.316
Country (W1) ^{b,c}	0-1	40.00	0.492	46.24	0.500	62.94	0.485

$P \leq 0.05$ between ^a sex work and serving; ^b between sex work and styling; ^c between serving and styling. Analytic sample N : sex work (125); serving (173); styling (143). SD, standard deviation; W1, first wave; W2, second wave.

feel bad'. A comment by another worker echoed this sentiment: sex work 'is not very valued. It's very, it's obviously stigmatised and, yeah it's hard to be honest about um, yourself and what you do'.

Multivariate results

The selection analysis results are briefly summarised here as they are available elsewhere (McCarthy *et al.* 2014). They indicated that the odds of working in the sex industry at the time of the study were significantly greater for respondents whose parents received social assistance when the respondents were children, who were sexually or physically abused or who lived in a group or foster home and who had started in their current occupation at a later age. The odds of sex work decreased with years of education and the number of prior occupations. The IMR constructed from these results was significantly associated with the use of marijuana and the use of SLA drugs in reduced equations (but not alcohol) and in equations that included the IMR and occupation.

Multivariate results of factors that predict perceived stigma are also summarised here (results not shown but available upon request). As hypothesised, working in the sex industry had a moderately sized and significant association with perceived stigma ($b = 0.19$, $SE = .08$, $\beta =$

.14), independent of selection into sex work and the various control variables included in the analyses of drug use presented below. One other variable was also related to stigma: current poverty ($b = 0.32$, $SE = .05$, $\beta = .29$). The latter association underscored the connections between stigma and other disreputable statuses and behaviour (as do the bivariate associations between stigma and several other variables, including being from a non-heterosexual identity and the use of SLA drugs).

Table 2 *Negative binomial regression of second-wave drug use*

	<i>Socially more acceptable</i>					
	<i>Alcohol</i>		<i>Marijuana</i>		<i>Socially less acceptable</i>	
	(2.1)	(2.2)	(2.3)	(2.4)	(2.5)	(2.6)
Sex work (W1)	-0.046 (0.190)	-0.105 (0.184)	0.028 (0.374)	0.046 (0.367)	1.861** (0.434)	1.686** (0.439)
Serving (W1)	0.627** (0.159)	0.660** (0.155)	0.262 (0.291)	0.353 (0.285)	0.959* (0.462)	1.018* (0.472)
IMR	0.163 (0.145)	0.082 (0.138)	0.679** (0.217)	0.617** (0.218)	-0.087 (0.252)	-0.113 (0.267)
Prior drug use (W1)	0.066** (0.005)	0.069** (0.004)	0.093** (0.009)	0.092** (0.008)	0.171** (0.038)	0.169** (0.039)
Poverty (W1)	0.092 (0.141)	-0.050 (0.140)	0.343 (0.225)	0.263 (0.227)	0.525* (0.257)	0.331 (0.277)
Single (W1)	-0.049 (0.134)	-0.032 (0.133)	-0.210 (0.248)	-0.197 (0.245)	0.216 (0.316)	0.230 (0.328)
Romantic partner unemployed (W1)	-0.062 (0.197)	-0.100 (0.180)	0.102 (0.343)	0.182 (0.341)	0.398 (0.373)	0.398 (0.370)
Mental health (W1)	-0.143 (0.078)	-0.127 (0.076)	0.008 (0.141)	-0.010 (0.142)	0.085 (0.116)	0.062 (0.117)
Physical health (W1)	0.045 (0.076)	0.009 (0.070)	-0.103 (0.119)	-0.108 (0.120)	-0.009 (0.128)	-0.015 (0.128)
Age (W1)	-0.016* (0.006)	-0.015* (0.006)	-0.030* (0.012)	-0.030** (0.012)	-0.008 (0.015)	-0.007 (0.016)
Gender (W1)	0.112 (0.145)	0.116 (0.151)	0.668* (0.286)	0.625* (0.268)	-0.111 (0.295)	-0.077 (0.301)
Racial minority (W1)	-0.113 (0.159)	-0.089 (0.155)	-0.457 (0.280)	-0.466 (0.277)	0.009 (0.261)	0.062 (0.267)
Sexual minority (W1)	0.090 (0.183)	0.065 (0.173)	0.209 (0.316)	0.214 (0.313)	-0.029 (0.269)	0.005 (0.273)
Country (W1)	0.153 (0.131)	0.097 (0.128)	0.219 (0.229)	0.188 (0.227)	0.031 (0.228)	-0.009 (0.233)
Perceived stigma (W2)		0.374** (0.127)		0.323 (0.211)		0.485** (0.174)
Constant	1.813	1.182	1.998	1.425	-2.63	-3.335
Alpha	1.196	1.153	3.684	3.652	3.196	3.067
N	435	435	428	428	441	441

** $P \leq 0.01$, * $P \leq 0.05$ (two-tailed). Unstandardized regression coefficients; robust standard errors in parentheses. IMR, inverse Mills ratio; W1, first wave; W2, second wave.

Two multivariate equations were estimated for each measure of second-wave drug use (see Table 2). The first included occupation, the correction for selection, prior drug use and the control variables. The second added the measure of perceived stigma and assessed the extent to which stigma intervened or mediated (in this case reduced) the magnitude of the association between occupation and drug use. The results indicated that, compared to employment in the hair styling industry, working in the sex industry was significantly associated with SLA drug use (equation 2.5), but not the use of SMA drugs (equations 2.1 and 2.3). Meanwhile, employment in the serving sector was associated with more frequent use of alcohol and SLA drugs relative to working in styling. Incident rate ratios were used to estimate the size of associations. Accordingly, the expected incidence rate of SLA drug use was 6.4 times greater for people in sex work ($b = 1.86$) and 2.6 times larger for those in serving compared to those employed in styling ($b = 0.96$). The expected rate of alcohol use was 1.9 times greater for people in serving compared with those in styling ($b = 0.63$). As expected, the use of any drugs was strongly associated with prior drug use and including a measure in the models reduced the bivariate associations between most of the independent variables and current drug use. The notable exceptions to this pattern included associations between age and both alcohol ($b = -0.03$) and marijuana use ($b = -.003$) and between the latter and gender ($b = 0.067$).

The measure of perceived stigma was introduced in equations 2.2, 2.4 and 2.6. The results revealed no notable association between perceived stigma and marijuana use. In contrast, perceived stigma had sizable associations with the use of alcohol ($b = 0.37$) and SLA drugs ($b = 0.48$). The expected incidence rate of alcohol use increased by 1.4 with each one-unit increase in stigma, whereas the expected incidence rate of SLA drugs rose by 1.6. More important, mediation analysis (see MacKinnon 2008) indicated that perceived stigma was a significant mediator of sex work (Sobel coefficient = .20, $P = 0.03$) and explained about 15 per cent of its effect on SLA drug use. In contrast, adding perceived stigma to the equations was not a significant mediator of the association between working as a server and alcohol use (Sobel coefficient = .43, $P = 0.07$). Mediation analyses also revealed that perceived stigma was not a significant mediator of the relationship between prior and current drug use. However, it was a significant mediator of the relationship between current poverty and the use of SLA drugs (Sobel coefficient = 0.25, $P = 0.01$) and explained about 48 per cent of this association.³

Discussion

Goffman's work (1963) on the origins, nature and consequences of stigma provided a fertile ground for scientists from an array of disciplines who have used it to understand a diverse set of negative experiences and behaviour (Hatzenbuehler and Link 2014, Link and Phelan 2001, Prior *et al.* 2003). Yet much of this research is limited by its assumption that members of a deviant group are, by definition, stigmatised equally and by a failure to compare the experiences of members of stigmatised groups with others.

This article addressed these shortcomings in an analysis of the consequences of perceived stigma for substance use among three groups of workers. As Hughes (1958) observed over half a century ago, occupation is a key component of an individual's identity and self-image, and much of people's waking hours and years of their lives revolve around it. What one does for a living is also linked to a host of health outcomes, in part through its association with perceived stigma. Our comparative analysis of sex work and two other low-prestige feminised service occupations, food and alcohol beverage serving and hair styling, highlighted the particular social conditions that connect occupational status with perceived stigma and health behaviour such as drug use.

We found that some workers in each of these three occupations reported being discriminated against because of their job, but that perceived stigma was more pronounced among those who work in the sex industry. This outcome is not surprising, given the strong legal and moral prohibitions about buying and selling sex in countries such as the USA and Canada (McCarthy *et al.* 2012), and it resonates with patterns observed in other studies. Abel *et al.* (2010), for example, reported that many people employed in sex work echoed the dominant public discourse and described their work as shameful or degrading.

A related finding was that a large percentage of service workers use drugs, but that those involved in sex work report greater use of SLA substances. The analysis revealed that perceived stigma influenced the use of these drugs independently of prior use. Moreover, perceived stigma helped mediate the association between sex work and changes in SLA drug use over time. Although these results highlighted the intervening role of perceived stigma, the sizable association that remained between sex work and use of these drugs underscored the complexity of this relationship. This complexity is further emphasised in the contrasting findings for SMA drug use: people employed in the sex industry did not differ significantly from stylists in their use of more socially acceptable substances such as alcohol and marijuana, whereas serving was associated with the significantly higher use of these drugs (independent of prior consumption). Furthermore, there was no evidence that perceived stigma was significantly linked to SMA drug use.

The findings suggest that the perception of being discriminated against by others is one of the most consequential components of stigmatisation (Link and Phelan 2001, Phelan *et al.* 2008). The connection between perceived stigma and the use of SLA substances may reflect an attempt by stigmatised individuals to cope, at least temporarily, with their poor treatment by others (Keusch *et al.* 2006). It is no coincidence that sex work and stigma jointly contributed to the use of a class of drugs that is also intensely stigmatised, creating a high-risk work environment that produces further harm (Rhodes 1997). Compared to SMA drug use, the use of SLA substances is more likely to result in being labelled a 'drug addict/abuser' (Corrigan *et al.* 2009) and for many people, the use of these drugs is essentially a 'stigma life sentence' (Lloyd 2010: 46). The increased use of one such drug – crack cocaine – in the 1980s and 1990s by people involved in the sex industry resulted in the highly stigmatising identity 'crack whore' (Fullilove *et al.* 1992, Maher 1996), even though research has shown that the recreational use of the drug by workers and their clients does not necessarily create difficulties for workers (Green *et al.* 2000).

The connections between sex work, perceived stigma and SLA drug use may also reflect patterns in which those who are most vulnerable to a moral condemnation of what they do for a living are least able to buffer themselves against the damaging impact of how people treat them. Compared with the two other occupations examined in this article, people in the sex industry are more likely to grow up in poverty and unstable circumstances, to be victims of neglect or abuse, to have a limited education and poor economic prospects and to have few resources to protect themselves against the damaging impact of how people treat them. As a result, many find themselves in what Wailoo (2006) refers to as a web of stigmatisation.

Limitations and future prospects

The links between sex work, stigma and drug use clearly warrant further research. Future studies should consider the consequences of other factors, such as work-related stress and exposure to violence, and aim for a sample that is larger and broader than our two-city sample.

Researchers should also study the possibility and consequences of the courtesy stigma (Goffman 1963) among those who interact regularly with sex workers, including managers and owners of sex work establishments, their intimate partners and others (Phillips *et al.* 2012).

This study used a combination of original and previously used items to measure perceived stigma. Subsequent research should continue to examine various ways to measure stigma in order to develop and validate measures that can be employed to study the concept in a wide array of settings and across different groups (Mak *et al.* 2007). Although the variety of conceptual and measurement approaches to stigma is a consequence of its use by an array of disciplines (Link and Phelan 2001), Prior *et al.* (2003: 2191) note that the diversity is not without costs: as a concept, stigma:

Is creaking under the burden of explaining a series of disparate, complex, and unrelated processes to such an extent that use of the term is in danger of obscuring as much as it enlightens.

Much work must be done to develop a coherent and sustainable theory of stigmatisation that will facilitate empirical research (Deacon 2006, Hatzenbuehler *et al.* 2013). However, we should not let such theoretical concerns deter us from recommending immediate action to reduce the impact of stigma on sex workers' life chances. Our findings call for a more humane view of those who make a living in the sex industry, a view that emphasises their agency and human rights. Any policy interventions to reduce prostitution stigma should be led by those with lived experience, as their voices and insights will be the most effective in designing harm-reduction strategies that challenge the pervasive power of those who want to keep sex workers 'down, in or away' (Link and Phelan 2014: 24), and left to rely on addictive substances to cope with their structural situation.

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Acknowledgements

This research was funded, in part, by the Canadian Institutes of Health Research and by the Canadian Studies Grant Program. We wish to thank those who participated in the interviews. Without their input, this work would not have been possible. Finally, we acknowledge the astute feedback from the reviewers and *Sociology of Health & Illness* editorial team.

Notes

- 1 Following the announcement of this study and its funding by the Canadian Institutes of Health Research, the local *Victoria Times Colonist* newspaper published an editorial arguing that the study delivers the 'insult of lumping hard-working, law-abiding waitresses and hairstylists with "sex workers"'. It also published a commentary by the secretary-treasurer of the Cosmetologists' Association of B.C. who claimed that the study draws dubious and unfair comparisons between sex workers, food and beverage workers and hairstylists.
- 2 The second equation in the original Heckman correction is an ordinary least squares (OLS) model; however, the correction is widely used in other regression models. The same substantive results as those reported occur if the drug measures are treated as normally distributed and analysed with OLS regression (for example, equation 2.6 estimated in OLS: sex work ($b = 1.163$, $SE = .424$, stigma $b = 0.972$, $SE = .263$).

- 3 Comparable results, albeit smaller in magnitude, occur with models that use a measure of stigma that includes only items related to health care providers.

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